REPORT OF THE URBAN HOSPITAL COUNCIL WORKING GROUP ON PSYCHIATRIC SERVICES

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CONTENTS

Preamble

Executive Summary

1. Introduction..... 1

2. Review Process..... 2

2.1 Working Group Membership..... 2
2.2 Preliminary Areas of Consensus..... 3
2.3 Sources of Information..... 4
2.4 Consideration of Options..... 4

3. The Proposal..... 5

3.1 Summary Description..... 5
3.2 Current Services of Misericordia Psychiatry..... 8
3.3 Key Considerations Underlying the Proposal..... 9
3.4 Service Requirements..... 10

4. Implementation..... 11

4.1 Governance..... 11
4.2 Preliminary Description of Process, Scheduling, and Estimated Financial Implications..... 12

5. Discussion..... 13

Appendix..... 15

PREAMBLE:

The basic challenge for mental health reform in the urban environment of Winnipeg is to identify the most appropriate "service mix"--the appropriate combination of acute care psychiatric beds and community based services--so that a full spectrum of services is available to respond to the needs of individuals throughout the city.

The first step in meeting this challenge has been a review of the current number and utilization of acute care psychiatric beds in Winnipeg hospitals with the result that twenty acute care beds could be removed from service as soon as appropriate community based services can be developed. Beyond this, the ultimate goal is to develop plans that, over time, will alter the current service system to enhance the scope and role of community based services. This shift is consistent with the principles and policies upon which the province wide reform of mental health services is based, and will result in further replacements of acute care psychiatric beds with alternative services.

To achieve this goal, the Assistant Deputy Minister, Provincial Mental Health Services--working under direction of the Urban Hospital Council--is currently chairing a working group to examine and recommend ways to manage acute care psychiatric beds more effectively as part of an integrated system of mental health services, and to develop a multi-year plan to accomplish this.

In the present submission, the working group recommends a reduction of twenty psychiatric beds, from the Winnipeg complement, following establishment of an appropriate spectrum of alternative, community-based services. Ongoing work of this subcommittee will involve identification of alternative community based services that can reduce the number of acute care beds that are needed to meet community needs, thus ensuring appropriate and effective use of the acute care component of the service system.

EXECUTIVE SUMMARY

In April of 1991, a Working Group of The Urban Hospital Council was convened to consider major options for the reform of psychiatric services in the city of Winnipeg. Members included representatives of the Mental Health Division, Winnipeg teaching and community hospitals, and the Manitoba Health Services Commission.

Committee members agreed to conduct their review according to terms of reference of the Council, and the following general premises: 1) that the principle objective of the exercise be to initiate reform of mental health services in Winnipeg, 2) that options be framed on a replacement of twenty beds, from within Winnipeg hospital psychiatry departments, with an appropriate spectrum of community-based alternative services, per specific directive of Council, 3) that alternative resources be scheduled for full operation prior to any suspension of hospital-based services, and 4) that key figures from within the Winnipeg mental health community be consulted in the course of the review.

Over the course of the review, the Working Group solicited input from a wide range of program and service representatives and advocates from within the Winnipeg mental health community.

Heads of each of the city's hospital psychiatry departments, accompanied by such staff as heads of nursing and administrators, each presented submissions. Three members of the Winnipeg Region Mental Health Council, including the Chair, were heard. Presentations and comment were also provided by the Mental Health Coalition, including the Executive Director of the Canadian Mental Health Association, Manitoba Division, staff of the Social Planning Council of Winnipeg, and representatives of two consumer and self-help organizations: Manitoba Friends of Schizophrenics, Inc., and the Society of Depression and Manic Depression (Coalition Chair).

The major proposal of the Working Group involves a replacement of services currently provided by the Department of Psychiatry at the Misericordia General Hospital. Recommended alternative services include:

1) Transfer of the Moditen clinic currently based at the Misericordia Hospital to the Winnipeg regional office at 189 Evanson Street,

2) Expansion of the Salvation Army, Crisis Stabilization Unit (increase bed count to 14, from the current 8),

3) Expansion of the existing Winnipeg Region, mobile crisis team (increase staff by 2.0 SY),

4) Development of a staffed, 8 bed residence for former inpatients who, owing to the nature of their illness, experience severe difficulty living with any degree of independence in the community,

5) Consideration of transfer of existing psychiatric day services, from Misericordia to the Psychealth facility of the Health Sciences Centre, and/or to a regional external agency,

6) Consideration of transfer of existing psychiatric outpatient services, from Misericordia to the authority of the Health Sciences Centre Department of Psychiatry. Option should involve transfer of appropriate, existing resources; if not practical, consideration of establishing multidisciplinary, direct service team within the Health Sciences Centre Department of Psychiatry, and

7) Consideration of a special fund in support of consumer and/or self-help organizations (new and existing proposals to be reviewed for consistency with long-term strategic planning of the Mental Health Division).

Annual recoveries, on full implementation, are estimated at $ 400,000.00. This is based on a conservative estimate of $ 1.2 million recovery from the Misericordia General Hospital. Cost recovery would follow on a thorough review of M.G.H., departmental operating costs (one full floor of the hospital would be put effectively out of service).

The proposal has the immediate implication of suspending plans to expand inpatient psychiatry resources of the Misericordia General Hospital.

SECTION ONE: INTRODUCTION

During the spring of 1991 the Minister of Health established the Urban Hospital Council, a planning group mandated to develop broad-based strategies for implementation of the Province's Goals for Health and Health Care. Reporting to the Minister of Health, the Council is chaired by the Deputy Minister of Health, and includes Chief Executive Officers of the province's major urban hospitals, the Executive Director of Manitoba Health Organizations Inc., the Regional Director of Winnipeg Region Health and Family Services, the Executive Director of the Manitoba Health Services Commission, and the Director of Manitoba Health, Facilities Division.

The central goal of the Council is to oversee planning, towards development of modern, alternative systems of health service delivery which are both clinically sound and progressive, optimally efficient, and consistent with broader reform initiatives of Manitoba Health.

The Council is supported by a structure of Working Groups, each involving senior Departmental staff and leading health professionals from within Manitoba, which examine and provide recommendations on a range of specialty service areas.

One of these is the Working Group on Psychiatric Services. With representatives of urban teaching and community hospital Departments of Psychiatry, the Mental Health Division of Manitoba Health, and the Manitoba Health Services Commission, this group undertook a preliminary review of hospital psychiatric services according to guidelines listed below (a detailed statement of principles and guidelines, common to all Working Groups, appears in Appendix). The immediate, specific assignment of the group was to identify twenty psychiatric beds for possible replacement with an appropriate spectrum of alternative, community-based services.

REVIEW OF PSYCHIATRIC SERVICES

1. Review the current utilization of psychiatric services in Winnipeg hospitals.

2. Review and comment on the need for psychiatric services in all Winnipeg hospitals currently providing this service.

3. Identify an implementation plan for any recommended changes in the provision of psychiatric services in Winnipeg hospitals.

While this formed the basis of a time-limited assignment, the Working Group identified clear connections between terms of reference provided by the Council, and the broader framework for reform outlined in the Department's Vision for the Future: Guiding Principles and Policies for Mental Health Services. Most important, the Council's process itself provided a unique opportunity for nongovernmental health professionals, Departmental staff, and community representatives to collaborate on a major change initiative.

Beyond this, however, there appeared to be important points of convergence between goals of the Council, and directions, shared by the Department and the broader mental health community, regarding modernization of provincial mental health services. Both held substantial potential for achieving efficiency, through linkages among system components, and development of superior models of care, in which modern hospital psychiatry is supported by a spectrum of rehabilitative and supportive services in the community.

The following, then, outlines major findings of the Working Group. Section two provides an overview description of method, and preliminary areas of consensus. The major proposals of the group are outlined in section three. Sections four and five provide a precursory model of implementation, summary statements, and discussion on the review process itself.

SECTION TWO: REVIEW PROCESS

2.1 Working Group Membership:

Composition of the Working Group was structured to provide senior representation from both Departmental administration, and core hospital and community systems under review. Members included:

Mr. R. Toews Assistant Deputy Minister Provincial Mental Health Services Manitoba Health	Chairperson
Dr. W. Bebchuk Head of Department of Psychiatry University of Manitoba and Health Sciences Centre	Representing Teaching Hospitals

Dr. D. Hershberg Head of Psychiatry Department of Psychiatry Victoria General Hospital	Representing Community Hospitals
Mr. R. Cowan Director Mental Health Programs Mental Health Division Manitoba Health	Representing the Mental Health Division, the Regional Mental Health Program, and Mental Health External Agencies
Mr. Sean Drain Director Facilities Manitoba Health Services Commission Manitoba Health	Representing the Manitoba Health Services Commission

Analytic support was coordinated by planning staff of the Mental Health Division, Dr. A. Islam, Senior Policy Analyst, and Mr. G. Pronyk, Program Specialist: Education/Forensic.

2.2 Preliminary Areas of Consensus:

At the outset of the process, Working Group members agreed that the review would be grounded in a number of premises. First, Members were unanimous that all proposals developed should foster improvement of the mental health system in Winnipeg. Members saw a high degree of compatibility between requirements of the Council, and various reform initiatives outlined by the Minister of Health. In particular, it was acknowledged that if done well, the exercise could provide impetus for the development of modern community alternatives, and serve as a catalyst for improved working relationships among urban hospitals, Manitoba Health regional operations, private agencies and consumer groups.

Second, the group agreed to identify twenty psychiatric beds for possible replacement with an appropriate spectrum of alternative, community-based services. The group accepted as information that Winnipeg has the highest rate of hospital psychiatry beds of all major Canadian cities (42.9/100,000, compared with the next highest rates of 39.6/100,000 for the city of Victoria, and 33.8/100,000, for Saskatoon).

Third, it was agreed that any consideration of bed reductions should be accompanied by planning towards the development of alternative, community-based services. Further, there was clear consensus that for reasons of patient care and public safety, proposed community resources must be in place prior to any reduction of hospital services.

Finally, members acknowledged that any major systemic change within the Winnipeg mental health system would require significant, and sustained, interjurisdictional cooperation. As such, it was agreed that key stakeholders should be invited to provide submissions to the review, both to ensure that the group was adequately informed, and to lay a clear framework for meaningful partnership in the future.

2.3 Sources of Information:

Over the course of the review, the Working Group solicited input from a wide range of program and service representatives and advocates from within the Winnipeg mental health community.

Heads of each of the city's hospital psychiatry departments, accompanied by resource staff such as heads of nursing and administrators, each presented submissions. Three members of the Winnipeg Region Mental Health Council, including the Chair, were heard. Presentations and comment were also provided by the Mental Health Coalition, including the Executive Director of the Canadian Mental Health Association, Manitoba Division, staff of the Social Planning Council of Winnipeg, and representatives of two consumer and self-help organizations: Manitoba Friends of Schizophrenics, Inc., and the Society of Depression and Manic Depression (Coalition Chair).

Through staff resources, the group also reviewed a great deal of data drawn from the Manitoba Health Services Commission, and considered a range of information concerning contemporary models of community mental health service delivery. In addition, a survey instrument was developed specifically for the review, which captured information on current and prior years' activity of all six, Winnipeg hospital psychiatry departments.

All statistical and programmatic information on mental health services was made accessible to the Working Group on a priority basis. Beyond, this, however, it was acknowledged that qualitative information on patients' needs and preferences should figure prominently into any major decisions. As such, all modeling of options considered current diagnostic distribution, across inpatient services, as well as patients' social circumstances, and likely preferences regarding service consumption in the event of a major change process.

2.4 Consideration of Options:

In the process of reviewing options, a variety of variables were considered separately and in combination. Most

important, as noted, were patients' needs, as evidenced by both diagnostic information and members', and presenters', direct experience with consumers in each of the city's hospitals.

In addition to this, the group weighed implications of targeting a single site for reduction, as compared with a strategy of distributing reductions across the system as a whole. Impacts of identifying acute and extended care beds were examined, as were various issues unique to teaching, inner city and community hospitals. The physical plant of each of the Departments was also considered.

As community resource development was believed pivotal to implementation, each of the hospitals was considered in respect of its proximity to existing resources, and direct and functional relationships with nonhospital-based mental health services.

A number of factors were conspicuous for their exclusion from the review process. The Working Group did not consider personnel characteristics. All staff likely to be affected by any proposal were recognized for an equivalent, high level of skill and commitment to their professions.

Proposals which on the face of it were attractive on the basis of savings were rejected, if it was believed they were not optimally desirable from a clinical perspective. That is, members were unanimous in their position that the review should reflect the principles and approaches of reform.

SECTION THREE: THE PROPOSAL

3.1 Summary Description:

The proposal of the Working Group calls for the scheduled replacement of all psychiatric inpatient, outpatient and day treatment services currently provided by the Misericordia General Hospital, with an appropriate spectrum of alternative, community-based services. This proposal has the immediate implication of suspending plans to expand inpatient psychiatry resources of the Misericordia General Hospital.

Services Provided at Misericordia General Hospital:

The Misericordia General Hospital currently provides the following psychiatric and related mental health services: 21 acute care in-patient psychiatric beds; outpatient services including access to two psychiatrists; day hospital; Moditen

clinic; and referral services (primarily to the Winnipeg Region community mental health program and the Salvation Army Crisis Stabilization Unit).

New Directions:

Conversion of services of Misericordia Psychiatry to nonhospital-based, alternative resources is broadly consistent with expressed principles and policies of Manitoba Health. One of the central objectives of the initiative would be to establish a single locus of responsibility for a group identified by the Department as requiring priority consideration in service planning (persons who experience severe and persistent mental illness). Service development would be consistent with Departmental policies concerning modernization of the spectrum of hospital and community-based service systems.

Programs and services required prior to closure of the department would include:

1) Transfer of the Moditen clinic currently based at the Misericordia Hospital to the Winnipeg regional office at 189 Evanson Street,

2) Expansion of the Salvation Army, Crisis Stabilization Unit (increase bed count to 14, from the current 8),

3) Expansion of the existing Winnipeg Region, mobile crisis team (increase staff by 2.0 SY),

4) Development of a staffed, 8 bed residence for former inpatients who, owing to psychiatric impairment and associated behavioural problems, experience severe difficulty living with any degree of independence in the community,

5) Consideration of transfer of existing psychiatric day services, from Misericordia to the Psychealth facility of the Health Sciences Centre, and/or to a regional external agency,

6) Consideration of transfer of existing psychiatric outpatient services, from Misericordia to the authority of the Health Sciences Centre Department of Psychiatry. Option should involve transfer of appropriate, existing resources; if not practical, consideration of establishing multidisciplinary, direct service team within the Health Sciences Centre Department of Psychiatry, and

7) Consideration of special fund in support of consumer and/or self-help organizations (new and existing

proposals to be reviewed for consistency with long-term strategic planning of the Mental Health Division).

In light of the planned expansion of the Health Sciences Centre Psychiatry Department, it will be important that the hospital work in close partnership with area programs and services (particularly the St. Boniface Hospital Emergency Department), and that any new community resources are provided with corresponding obligations back to Manitoba Health and Regional Operations (including willingness to deal with all persons requiring admission under the Mental Health Act).

Supplementary Benefits of the Initiative:

1) Improved services to persons who experience major or chronic psychiatric disorder (target population) at major teaching facility.

2) Single responsibility centre for persons suffering severe and persistent mental illness.

3) Target population experiences greater and increased access to psychiatric resources.

4) Increased coordination between Winnipeg Region and Health Sciences Centre (core relationship with one hospital rather than two).

5) Rehabilitation Services (social service functions such as housing, employment, etc.) combined with best elements of community psychiatry should lead to an improved service delivery system.

6) Community based treatment (all above-cited components) in keeping with "Wisconsin Model" and directions described in all recent literature; also consistent with the Minister's reform initiatives.

Opportunities for Future Reform:

1) Opportunity to establish a centre for applied research, involving the Department of Psychiatry and associated professions, based at major teaching hospital.

2) Opportunity to demonstrate humane, cost-effective methods of community care.

3) Opportunity to develop a centre for excellence at Health Sciences Centre (on a scale of Clarke Institute: Toronto).

4) Opportunity to involve all partners (hospital, community, region, and mental health councils, and consumers) in strategic and operational planning.

3.2 Current Services of Misericordia Psychiatry:

Inpatient Services:

Misericordia General Hospital has 21 acute care psychiatric beds. Although the hospital as a whole has an occupancy rate of 79.1% (1989/90), that of the psychiatry department has traditionally been much higher (96.6% in 1988/89; 97.2% in 1989/90).

In 1987/88, the hospital discharged a total of 434 patients with a primary psychiatric diagnosis. 317 of these were discharged from the 21 bed, inpatient psychiatry unit. A summary of patient separations and average length of stay, from the unit, appears below:

Year	Number of Separations	Average Length of Stay (based on Separations)
1990/91	335	23.0
1989/90	296	36.0
1988/89	319	23.1
1987/88	317	17.3
1986/87	360	18.9

Average length of stay in the department showed a steady increase between 1986/87 (18.9 days) and 1989/90 (36.0 days). A significant decrease, however, was reported for 1990/91 (23.0 days), an event likely attributable to the department's relationship with the Salvation Army, Crisis Stabilization Unit. Over the years, average length of stay has tended to be comparable with that of other inpatient psychiatry units in Winnipeg hospitals. Rates are markedly lower, however, than those for St. Boniface General Hospital, which for 1990/91 reported an average length of stay of 37.0 days. (This was the highest rate reported by the six Winnipeg hospitals surveyed.)

The 21 bed acute care psychiatry unit at the

Misericordia serves a large number of young to middle-aged persons from the inner city area of Winnipeg. Eight of the 21 inpatients, at March 31, 1991, were younger than 45 years. Seven of the 21 presented with a primary diagnosis of schizophrenia (3 with a secondary diagnosis of bipolar affective disorder of major depression). Four of the 21 presented with a primary diagnosis of bipolar affective disorder.

According to discharge statistics, a majority of inpatients were women (57% in 1989/90; all other departments, with the exception of Health Sciences Centre, also reported a majority of female inpatients during this period). Of the 21 inpatients at March 31, 1991, 10 were described as awaiting placements. Four of these were awaiting admission to a staffed community residence, 2 for personal care homes, 2 for institutional admission, and 2 for home or other psychogeriatric placement. Six of the ten had been inpatients (current admission) five weeks or longer, at the point that desired placement was indicated.

Outpatient/Day Treatment Services:

The outpatient department of Misericordia psychiatry serves roughly 1,800 persons a year, most of these being former hospital inpatients. The Misericordia also has a day treatment program (Day Hospital) with a space complement for 40 clients per day. The rate of use is relatively low (40% in 1987/88), a fact which the hospital attributes to funding arrangements which provide for use of 25 spaces per day. (With the exception of Seven Oaks General Hospital, rates of use in other comparable units in the city are similarly low.)

3.3 Key Considerations Underlying the Proposal:

A great many variables, both statistical and qualitative, influenced the Working Group's final proposal. The group wishes to emphasize, however, that very few of these reflected a consideration of the comparative merits for the six hospitals' services and facilities. Again, it was recognized by the group that all units provided services of high quality to persons with challenging care requirements, and that any reduction would need to be accompanied by alternative resources in the community.

If anything, variables of focus related to the hospitals' strengths, as measured by their capacity to collaborate in a major change process. In the case of the Misericordia Hospital, factors of central consideration included the psychiatry department's close, functional relationship with the Winnipeg Region mental health program, and the Crisis Stabilization Unit, two services pivotal to alternative resource

development.

Other factors included the hospital's physical plant, and historical problems concerning recruitment of psychiatrists to the M.G.H. Department of Psychiatry. The hospital's catchment area was also considered. Existing hospital services, in particular the Health Sciences Centre and St. Boniface Hospital Emergency Department, serve a large number of persons living in close proximity to the Misericordia General Hospital. On consideration of diagnostic, social and geographic criteria, it was felt that patients of the Misericordia Hospital would likely be able to make a safe transition to other services within Winnipeg's inner city.

This observation was generally shared by community representatives, who expressed that of all possible options, closure of the older facilities of the Misericordia Hospital would be the most acceptable.

3.4 Service Requirements:

1) Relocate Moditen Clinic currently operated at Misericordia General Hospital to 189 Evanson Street. Combine services with Moditen Clinic now carried at 189 Evanson Street. Redirect the equivalent of 2 staff years and current operating budget of the M.G.H. Moditen Clinic.
.....$ 70,000.00

2) Expand existing Salvation Army Crisis Stabilization Unit, from 8 beds to 14 beds, and earmark/designate the newly created beds for Misericordia General Hospital patient/clients who do not require services under the Mental Health Act (ie., do not need to be placed in a designated psychiatric facility).
.....Estimated Cost: $ 350,000.00 (annualized)

3) Expansion of the existing Winnipeg Region, mobile crisis team (increase by 2.0 SY).
.....Estimated Cost: $ 80,000.00 (annualized)

4) Development of a staffed, 8 bed residence for former inpatients who, owing to psychiatric impairment and associated behavioural problems, experience severe difficulty living with any degree of independence in the community (6 SY, 5 at RPN level III and 1 at HSIV; room and board payments provided through the Social Allowances Program of Manitoba Family Services).
.....Estimated Cost: $ 250,000.00 (annualized)

5) Consideration of transfer of existing day services, from the Misericordia General Hospital to the Health Sciences Centre, and/or an external agency. Appropriate resources (staff years and operating budget also transferred).
.....present cost to continue

6) Consideration of transfer of existing psychiatric outpatient services, from Misericordia to the authority of the Health Sciences Centre Department of Psychiatry. Option should involve transfer of appropriate, existing resources; if not practical, consideration of establishing multidisciplinary, direct service team within the Health Sciences Centre Department of Psychiatry.
.....present cost to continue

7) Consideration of special fund in support of consumer and/or self-help organizations (new and existing proposals to be reviewed for consistency with long-term strategic planning of the Mental Health Division).
.....Estimated Cost: $ 50,000.00 (annualized)

SECTION FOUR: IMPLEMENTATION

4.1 Governance:

It was agreed that implementation would require a substantial degree of ongoing cooperation, at various levels among a range of involved agencies and organizations. It was proposed, therefore, that a Planning/Implementation Committee be established, including senior representatives of both the Mental Health Division, the Manitoba Health Services Commission, the Misericordia General Hospital and Health Science Centre, Winnipeg Regional Operations, and the Winnipeg Region Mental Health Council.

The committee should report to senior staff of the Manitoba Health, Mental Health Division. As was the case with the Working Group, the committee should solicit ongoing information from within the mental health community in Winnipeg, with analytic support provided by planning staff of the Mental Health Division.

4.2 Preliminary Description of Process, Scheduling, and Estimated Financial Implications

As noted, there is consensus that the success of the proposal is absolutely dependent upon community resources being developed prior to any suspension of hospital-based services. Further, it was agreed that the Misericordia reduction should not be fully implemented until the services of the Health Sciences Centre, Psychealth facility, are in place and operational (fall of 1992). Implementation planning would allow, however, for a potential phased closure of M.G.H. psychiatry beds prior to that date.

It was also suggested that negotiations commence regarding the feasibility of making extended care beds, of the Grace General Hospital Department of Psychiatry, available as a city wide resource.

The Working Group also proposed that the Planning/ Implementation Committee enlist the aid of all Winnipeg Hospitals to make optimal use of acute and extended care beds during the implementation period. Special efforts would be made by the Committee, and all partners in the process, to make provision to accommodate long stay hospital patients in alternate facilities.

Beyond this, it was identified that implementation would require at the least a summary needs assessment, focussed on patients currently using psychiatric services of the Misericordia General Hospital. This should be followed by ongoing, formative evaluation, undertaken by staff of the Mental Health Division on behalf of the Planning/Implementation Committee.

The first year of the initiative, then, would see development of a spectrum of community-based mental health services, producing a recurring cost of approximately $ 800,000.00. Early in year 2, psychiatric services of the Misericordia Hospital would be suspended, with ongoing recoveries estimated at $ 1.2 million. It is essential to note that bridge funding will be required to put the alternative services in place before the planned reduction can occur.

COST SUMMARY (PRELIMINARY ESTIMATE)

(i) - Reductions:

21 Acute Care Bed Closure:	$	1,000.0
Day Services		200.0
Total		1,200.0*

(ii) Replacement Costs:

Moditen Clinic Transfer	$	70.0
C.S.U. Expansion		350.0
Mobile Crisis Team Expansion		80.0
8 Bed Residence		250.0
Transfer M.G.H. Day Services		nil**
Transfer M.G.H. Outpatient Services		nil**
Fund for Self-Help/Consumer Groups		50.0
Total		800.0

ANNUAL SAVING (YEAR 2) 400.0*

* Conservative estimate. Cost recovery would follow on a thorough review of M.G.H., departmental operating costs (one full floor of the hospital would be put effectively out of service).

** If programs and associated resources (2 full-time psychiatrists; other staff positions; number of patient spots in day services remains the same) are transferred to the Health Sciences Centre Psychealth facility, no new costs would be incurred. Should Misericordia medical staff refrain from relocating their practices to the Health Sciences Centre, it is not expected that costs associated with the care of former Misericordia patients would increase.

SECTION FIVE: DISCUSSION

The review, though comparatively brief, has been a most challenging, and at times apprehensive process. All Working Group members acknowledged, however, that there existed an opportunity to initiate important changes in the spectrum of community mental health services. No recent planning exercise, of this kind, has

demanded such specific recommendations for so major a reform of mental health services in the city of Winnipeg.

Given the success of the current undertaking, the Working Group sees it as important that it continue its efforts to examine the nature and distribution of psychiatric services throughout the whole of Winnipeg region. In this regard, it is seen as vital that a solid data base be established to permit informed examination of both the clinical, programmatic, and financial implications of proposals for future reform.

The core proposal, as outlined in the preceding, recommends substantial changes in the provision of urban psychiatric services. It should be reemphasized, however, that the caveats noted are absolutely essential to implementation. Of particular importance, no reduction in hospital services should occur prior to establishment of the recommended alternatives.

Beyond this, efforts must be made to maintain strong and open partnerships throughout all phases of this initiative. Like the review process itself, safe and successful implementation will require professional judgement, ongoing cooperation, and strong commitment to protect the interests of, in the case of the present exercise, a rather large number of vulnerable people.

APPENDIX

WORKING GROUPS

TERMS OF REFERENCE:

A) General Principles

Planning will proceed on the basis of re-allocation of appropriate services and patients from:

1) - tertiary hospitals to community hospitals
   - community hospitals to regional hospitals and
   - regional hospitals to district hospitals

2) - acute hospitals to chronic/rehabilitation hospitals and to personal care homes

3) - acute or long-term hospitals to the community

4) - eliminate any unnecessary duplication

5) - consolidate programs where it make economic sense and does not adversely affect service delivery

B) Specific Guidelines

Specific Guidelines for each working group are:

1) That present utilization be reviewed

2) That recommendations be in accord with the general principles

3) That an implementation plan be developed